FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026286

Facility Name: Holy Family Health Center

Address: 2380 East Dempster (Number) | Des Plaines (City) | 60016 (Zip Code)

County: Cook

Telephone Number: 847 296-3335 **Fax #** 847 296-2027

IDPA ID Number: 363121158001

Date of Initial License for Current Owners: 5/1/1981

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Effie Galetsis **Telephone Number:** 312 207-1040

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 06/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) See Accountants Compilation Report
(Firm Name & Address) Blackman Kallick Bartelstein, LLP, 300 South Riverside Plaza, Chicago, IL 60606
(Telephone) 312 207-1040 Fax # 312 207-1066

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	18,462	1
2		Skilled Pediatric (SNF/PED)			2
3	260	Intermediate (ICF)	260	47,060	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	362	TOTALS	362	65,522	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,297	4,666	4,211	12,174	8
9	SNF/PED					9
10	ICF	12,910	8,892	0	21,802	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,207	13,558	4,211	33,976	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.85%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 5/1/81

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 5/1/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 51 and days of care provided 4,211

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary		356	332,135	332,491		332,491		332,491			1
2	Food Purchase		182,161		182,161		182,161	(6,753)	175,408			2
3	Housekeeping	178,206	18,553	1,740	198,499		198,499		198,499			3
4	Laundry	87,600	25,171		112,771		112,771		112,771			4
5	Heat and Other Utilities			151,459	151,459		151,459	(557)	150,902			5
6	Maintenance	84,314	15,961	28,275	128,550		128,550	(128)	128,422			6
7	Other (specify):*	24,227			24,227		24,227		24,227			7
8	**TOTAL General Services**	374,347	242,202	513,609	1,130,158		1,130,158	(7,438)	1,122,720			8
	B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	2,007,226	64,523	4,190	2,075,939		2,075,939		2,075,939			10
10a	Therapy	237,154	20,541	31,987	289,682		289,682		289,682			10a
11	Activities	105,844	2,097	3,209	111,150		111,150		111,150			11
12	Social Services	64,947	74	1,050	66,071		66,071		66,071			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,415,171	87,235	50,936	2,553,342		2,553,342		2,553,342			16
	C. General Administration											
17	Administrative	101,864	786	98,084	200,734		200,734		200,734			17
18	Directors Fees											18
19	Professional Services			10,266	10,266		10,266		10,266			19
20	Dues, Fees, Subscriptions & Promotions			3,109	3,109		3,109	(1,597)	1,512			20
21	Clerical & General Office Expenses	84,482	48,382		132,864		132,864	(18,976)	113,888			21
22	Employee Benefits & Payroll Taxes			758,919	758,919		758,919		758,919			22
23	Inservice Training & Education			5,103	5,103		5,103		5,103			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,670	46,670		46,670		46,670			26
27	Other (specify):*											27
28	**TOTAL General Administration**	186,346	49,168	922,151	1,157,665		1,157,665	(20,573)	1,137,092			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,975,864	378,605	1,486,696	4,841,165		4,841,165	(28,011)	4,813,154			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Holy Family Health Center #0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			220,441	220,441		220,441	(933)	219,508			30
31	Amortization of Pre-Op. & Org.			(9,252)	(9,252)	(1,704)	(10,956)		(10,956)			31
32	Interest			128,450	128,450	1,704	130,154	(55,480)	74,674			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			339,639	339,639		339,639	(56,413)	283,226			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,343		175,343		175,343		175,343			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		236		236		236		236			41
42	Provider Participation Fee			98,283	98,283		98,283		98,283			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		175,579	98,283	273,862		273,862		273,862			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,975,864	554,184	1,924,618	5,454,666		5,454,666	(84,424)	5,370,242			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,753)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(55,480)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(236)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,447)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(18,740)	21		28
29	Other-Attach Schedule 5A	(1,618)	29		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (84,424)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (84,424)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Holy Family Health Center

ID# 0026286

Report Period Beginning: 01/01/2002

Ending: 06/30/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Convent-Supplies	$ (63)	6	1
2	Convent-Repairs	(65)	6	2
3	Convent-Electricity	(284)	5	3
4	Convent-Gas	(193)	5	4
5	Convent-Telephone	(80)	5	5
6	Convent-Depreciation	(933)	30	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,618)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Holy Family Health Center # 0026286 **Report Period Beginning:** 01/01/2002 **Ending:** 06/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,753)	0	0	0	0	0	0	0	0	0	0	(6,753)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(557)	0	0	0	0	0	0	0	0	0	0	(557)	5
6	Maintenance	(128)	0	0	0	0	0	0	0	0	0	0	(128)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(7,438)	0	0	0	0	0	0	0	0	0	0	(7,438)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,597)	0	0	0	0	0	0	0	0	0	0	(1,597)	20
21	Clerical & General Office Expenses	(18,976)	0	0	0	0	0	0	0	0	0	0	(18,976)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(20,573)	0	0	0	0	0	0	0	0	0	0	(20,573)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(28,011)	0	0	0	0	0	0	0	0	0	0	(28,011)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Holy Family Health Center # 0026286 **Report Period Beginning:** 01/01/2002 **Ending:** 06/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(933)	0	0	0	0	0	0	0	0	0	0	(933)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(55,480)	0	0	0	0	0	0	0	0	0	0	(55,480)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(56,413)	0	0	0	0	0	0	0	0	0	0	(56,413)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(84,424)	0	0	0	0	0	0	0	0	0	0	(84,424)	45

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sisters of the Holy Family	100%			Holy Family Medical	Des Plaines	Hospital
				Holy Family Health	Des Plaines	Health System
Resurrection Health Care	0	See attached Schedule 6A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Management Fees	$ 98,084	Resurrection Healthcare	0.00%	$ 98,084	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 98,084			$ 98,084	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection Healthcare
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 594-7837
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	L17, C3	Administrative Support	Direct Cost	9		$ 870,908	$	1	$ 98,084	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 870,908	$		$ 98,084	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	National City		x	Refinance		11/10/94	$ 5,623,000	$ 3,883,698	11/10/09		$ 130,154	1
2	Holy Family Medical Center	x		Purchase of Facility		5/1/81	1,800,000	1,800,000	Demand			2
3	Holy Family Medical Center	x		Purchase of Facility		5/1/81	600,000	600,000	Demand			3
4	Holy Family Medical Center	x		Purchase of Facility		5/1/81	600,000	600,000	Demand			4
5												5
	Working Capital											
6	Holy Family Medical Center			Working Capital		various	5,339,335	2,818,749	Demand			6
7	Resurrection Healthcare			Working Capital		various	2,924,622	2,924,622	Demand			7
8	Holy Family Medical Center			Working Capital		various	465,066	465,066	Demand			8
9	TOTAL Facility Related						$ 17,352,023	$ 13,092,135			$ 130,154	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(55,480)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (55,480)	14
15	TOTALS (line 9+line14)						$ 17,352,023	$ 13,092,135			$ 74,674	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

This page is N/A.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Holy Family Health Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026286

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 136,250 B. General Construction Type: Exterior Face Brick Frame Steel Number of Stories 6

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use		1981	$ 610,897	1
2	Business Use		1982-2000	312,530	2
3	TOTALS			$ 923,427	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	362		1981	1963	$ 5,610,288	$ 76,581	26	$ 76,581	$	$ 5,105,596	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1981	39,944	144	various	144		38,860	9
10	Land Improvements			1982	3,300		15			3,300	10
11	Land Improvements			1983	16,546		various			16,546	11
12	Land Improvements			1985	2,758		various			2,758	12
13	Land Improvements			1987	26,060		10			26,060	13
14	Land Improvements			1991	2,934		8			2,934	14
15	Land Improvements; Repaving dempster lot			1996	6,944	347	10	347		4,165	15
16	Land Improvements: Utility pole			1996	1,908	64	15	64		763	16
17	Building Improvements			1981	30,116	752	various	752		23,131	17
18	Building Improvements			1982	38,889	211	various	211		38,678	18
19	Building Improvements			1983	137,540	343	various	343		104,130	19
20	Building Improvements			1984	161,928	4,042	various	4,042		115,227	20
21	Building Improvements			1985	140,002		various			140,002	21
22	Building Improvements			1986	74,495	755	various	755		64,642	22
23	Building Improvements			1987	81,758	1,273	various	1,273		80,485	23
24	Building Improvements			1988	9,477	311	various	311		8,714	24
25	Building Improvements			1989	29,180	981	various	981		25,514	25
26	Building Improvements			1990	119,639	5,221	various	5,221		102,642	26
27	Building Improvements			1991	209,393	6,111	various	6,111		158,585	27
28	Building Improvements			1992	47,000	1,625	10	1,625		45,375	28
29	Building Improvements			1992	79,513	3,049	various	3,049		60,974	29
30	Building Improvements			1993	55,142	1,971	various	1,971		35,470	30
31	Building Improvements			1993	7,044	235	15	235		4,228	31
32	Building Improvements			1994	86,489	3,758	various	3,758		60,119	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Buidling Improvements #20-4	1995	$ 5,035	$ 229	11	$ 229	$	$ 3,205	37
38	Buidling Improvements #20-5	1995	5,469		5			5,469	38
39	Buidling Improvements #20-5	1995	7,988	515	11	515		6,415	39
40	Buidling Improvements #20-5	1995	3,648	183	10	183		2,555	40
41	Buidling Improvements #21-4	1995	94,827	4,311	11	4,311		60,347	41
42	Buidling Improvements #21-5	1995	34,922	1,588	11	1,588		22,225	42
43	Buidling Improvements #21-5	1995	1,423	71	10	71		995	43
44	Buidling Improvements #26-4	1995	6,906	230	15	230		3,221	44
45	Buidling Improvements #26-5	1995	6,358	212	15	212		2,968	45
46	Buidling Improvements: Carpeting for facility	1996	43,550		5			43,550	46
47	Buidling Improvements: Rudd water heater tank	1996	825	42	10	42		498	47
48	Buidling Improvements: Rekey/Lock/Latches	1996	13,413	447	15	447		5,364	48
49	Buidling Improvements: Upgrade East elevator	1996	35,024	876	20	876		10,507	49
50	Buidling Improvements: Wall covering in dining room	1996	7,240		5			7,240	50
51	Buidling Improvements: Phone system and call system	1996	44,556	2,228	10	2,228		26,736	51
52	Buidling Improvements: Remodeling 3rd floor patient rooms	1996	316,547	10,552	15	10,552		126,619	52
53	Buidling Improvements: Tiling of shower room	1996	1,355	34	20	34		408	53
54	Buidling Improvements: Cabinets and shower doors	1996	15,698	393	20	393		4,711	54
55	Double face exterior sign	1997	5,174	259	10	259		2,586	55
56	Refurbish 2404 sign (Business office)	1997	2,428	122	10	122		1,215	56
57	Sealcoating parking lot area	1997	3,804	190	10	190		1,900	57
58	Painting, Wallcovering, tile replacement of nursing station	1997	102,440	3,415	15	3,415		34,146	58
59	Heaters convector	1997	3,240	162	10	162		1,620	59
60	Emergency phones in elevators-West	1997	1,264	63	10	63		630	60
61	Air Dampers - East Building	1997	2,099	105	10	105		1,050	61
62	Boilers for East Building	1997	4,310	144	15	144		1,436	62
63	Carpeting Room 215	1997	650	14	5	14		637	63
64	Air Handler of West Building	1997	1,450	73	10	73		688	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 7,789,930	$ 134,222		$ 134,222	$	$ 6,647,829	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 7,789,930	$ 134,222		$ 134,222	$	$ 6,647,829	1
2	Painting, wallcovering, floor replacement of 2 West station	1998	34,662	1,156	15	1,156		9,245	2
3	Painting, wallcovering, floor replacement of 4 West station	1998	77,327	2,578	15	2,578		20,621	3
4	Painting, wallcovering, floor replacement of 5 West station	1998	76,450	2,549	15	2,549		20,389	4
5	30 Ton Chiller	1998	17,670	589	15	589		5,332	5
6	Fire Dampers in bath rooms	1998	7,135	238	15	238		1,904	6
7	Repair water main from Department 300	1998	3,887	195	8	195		1,556	7
8	Gutter replacement of east building	1999	6,400	320	10	320		1,920	8
9	Painting, wallcovering, floor replacement of 2 East station	1999	62,793	2,093	15	2,093		12,558	9
10	Replacement of Tran Compressor	1999	7,063	235	15	235		1,410	10
11	Call system upgrade 1 West	1999	33,238	1,662	10	1,662		9,972	11
12	Call system upgrade 3 West	1999	17,274	864	10	864		5,184	12
13	Painting, wallcovering, floor replacement of 4 West station	1999	2,082	69	15	69		414	13
14	Painting, wallcovering, floor replacement of Physical Therapy	1999	8,665	289	15	289		1,734	14
15	Construction of Parking Lot	2000	227,278	5,682	20	5,682		22,728	15
16	Landscaping	2000	7,208	361	10	361		1,442	16
17	Replace east elevator hydrolift	2000	33,472	1,116	15	1,116		4,464	17
18	Repair decking	2000	7,000	234	15	234		934	18
19	Door replacement	2000	3,035	152	10	152		608	19
20	Construction of Parking Lot	2001	15,451	407	19	407		814	20
21	2380 Building remodeling	2001	6,985	175	10	175		350	21
22	Freight elevator gate	2001	1,300	43	15	43		86	22
23	Door replacement	2001	3,378	141	12	141		282	23
24	Gas Steamer - connection with Booster	2001	7,507	250	15	250		500	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,457,190	$ 155,617		$ 155,617	$	$ 6,772,273	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,457,190	$ 155,617		$ 155,617	$	$ 6,772,273	1
2	Water Main Repair	2002	8,109	101	20	101	(0)	101	2
3	Building, Reception and office improvements	2002	199,513	3,325	15	3,325	(0)	3,325	3
4	Installation of new WEIL Pump	2002	3,438	172	5	172	0	172	4
5	Repair Flat Roof To Wood Deck	2002	9,445	236	10	236	(0)	236	5
6	Telephone cables	2002	16,900	423	10	423		423	6
7	Topographic Mapping of entire facility	2002	8,316	139	15	139	0	139	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,702,911	$ 160,013		$ 160,013	$ (0)	$ 6,776,669	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,447,238	$ 54,483	$ 54,483	$		$ 1,062,447	71
72	Current Year Purchases	19,881	710	710	(0)		710	72
73	Fully Depreciated Assets	830,058					830,058	73
74								74
75	TOTALS	$ 2,297,177	$ 55,193	$ 55,193	$ (0)		$ 1,893,215	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	1987 Ford Van	1992	$ 5,000	$	$	$		$ 5,000	76
77	Maintenance	1992 Ford F250	1992	18,860					18,860	77
78	Facility	1998 Saturn Wagon	1997	10,891					10,891	78
79	See attached schedule 13A			68,838	4,303	4,303			57,030	79
80	TOTALS			$ 103,589	$ 4,303	$ 4,303	$		$ 91,781	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,027,104	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 219,508	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 219,508	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,761,665	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 8,911 Description: Copier, $6,817; Postage Meter, $2,094
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C1&3	850 hrs	$ 21,585	90	$ 3,310	$	940	$ 24,895	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		113	5,750		113	5,750	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C1&3	3433 hrs	100,509	404	16,325		3,837	116,834	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				175,343		175,343	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 122,094	607	$ 25,385	$ 175,343	4,890	$ 322,822	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,546,895	$ 3,546,895	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 747,901)	1,696,808	1,696,808	3
4	Supply Inventory (priced at)	11,028	11,028	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	91,167	91,167	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,345,898	$ 5,345,898	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	923,427	923,427	13
14	Buildings, at Historical Cost	11,103,676	11,103,676	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(8,761,665)	(8,761,665)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Board Designated Funds	1,045,616	1,045,616	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,311,054	$ 4,311,054	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,656,952	$ 9,656,952	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	202,100	202,100	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expense	39,872	39,872	36
37	Due to Affiliates	9,208,437	9,208,437	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,450,409	$ 9,450,409	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,681,598	3,681,598	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,681,598	$ 3,681,598	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,132,008	$ 13,132,008	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,475,056)	$ (3,475,056)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,656,952	$ 9,656,952	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,257,675)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	122,999	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,134,676)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(340,380)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (340,380)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,475,056)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,808,860	1
2	Discounts and Allowances for all Levels	(2,101,023)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,707,837	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,027,422	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,027,422	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(885)	12
13	Barber and Beauty Care	(4,974)	13
14	Non-Patient Meals	7,526	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	243,058	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,762	19
20	Radiology and X-Ray	1,290	20
21	Other Medical Services	40,499	21
22	Laundry	15,319	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 314,595	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	55,480	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 55,480	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	8,952	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,952	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,114,286	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,130,158	31
32	Health Care	2,553,342	32
33	General Administration	1,157,665	33
	B. Capital Expense		
34	Ownership	339,639	34
	C. Ancillary Expense		
35	Special Cost Centers	175,579	35
36	Provider Participation Fee	98,283	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,454,666	40
41	**Income before Income Taxes (line 30 minus line 40)****	(340,380)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (340,380)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	920	1,190	$ 40,086	$ 33.69	1
2	Assistant Director of Nursing	64	88	2,733	31.06	2
3	Registered Nurses	1,128	1,291	18,874	14.62	3
4	Licensed Practical Nurses	35,666	43,379	1,038,321	23.94	4
5	Nurse Aides & Orderlies	69,420	81,693	933,715	11.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,395	4,183	116,045	27.74	7
8	Rehab/Therapy Aides	1,818	2,253	54,756	24.30	8
9	Activity Director	3,399	3,743	44,095	11.78	9
10	Activity Assistants	7,757	9,065	85,197	9.40	10
11	Social Service Workers	2,407	2,850	43,934	15.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	20,815	23,995	245,932	10.25	17
18	Housekeepers					18
19	Laundry	8,831	10,436	103,571	9.92	19
20	Administrator	1,040	1,040	53,249	51.20	20
21	Assistant Administrator	256	442	14,866	33.63	21
22	Other Administrative	7,389	8,353	128,412	15.37	22
23	Office Manager					23
24	Clerical	3,190	3,682	30,450	8.27	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,560	1,623	21,629	13.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,055	199,306	$ 2,975,865 *	$ 14.93	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	525	10,500	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	28	1,680	L10,C3	38
39	Pharmacist Consultant	99	4,140	L10,C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,916	L11,C3	44
45	Social Service Consultant	24	1,050	L12,C3	45
46	Other(specify)				46
47	Rehab Consultant	37	1,956	L10A,C3	47
48					48
49	TOTAL (lines 35 - 48)	749	$ 21,242		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	11	$ 499	L10,C3	50
51	Licensed Practical Nurses	30	1,043	L10,C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	41	$ 1,542		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sr. Elizabeth Tremb	Administrator	0	$ 53,249
Sr. Michaeline	Business Office	0	18,023
Norma Wanner	Secretary	0	18,339
John Koch	Asst Admininstratior	0	12,253
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,864

B. Administrative - Other

Description	Amount
Resurrection	$ 98,084
TOTAL (agree to Schedule V, line 17, col. 3)	$ 98,084
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ernst & Young	Audit	$ 500
BLACKMAN KALLICK	COST REPORT	7,430
HEALTHCARE VALUATION	FIXED ASSETS	1,800
DANA CONSULTING		536
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 10,266

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,595
Unemployment Compensation Insurance	5,080
FICA Taxes	204,282
Employee Health Insurance	417,372
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	5,077
Dental Insurance	17,274
HFHC Retirement	72,000
Employee Assistance	2,013
Tuition Reimbursement	3,445
Other benefits	(284)
Group Disability Insurance	18,065
TOTAL (agree to Schedule V, line 22, col.8)	$ 758,919

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	727
Health Care Worker Background Check	
(Indicate # of checks performed)	
Subscription	785
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,512

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
(agree to Sch. V, TOTAL line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Holy Family Health Center # 0026286 Report Period Beginning: 01/01/2002 Ending: 06/30/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. NO

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 17,451 Line 4

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 98,283
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? YES Indicate the amount. $ 6,753

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Holy Family Health Center
Provider # 0026286
6/30/2002

Reclassifications
Schedule 5B

	Increase	Line	Decrease	Line	Explanation
Interest Expense	1,704	32	(1,704)	31	To reclass interest expense from amortization expense

Holy Family
Provider # 0026286
Schedule 13A
Vehicle Depreciation

Description	Model	Year	Cost	Current Depreciation	S/L Depreciation	Life	Accumulated Depreciation	Line Ref
Resident Transport	1998 Dodge Caravan SS with wheel chair	1998	38,811	2,426	2,426	4	36,386	45
Facility	1998 Dodge 10 Passenger Van	1999	30,027	1,877	1,877	4	20,644	45
	Total		68,838	4,303	4,303		57,030	

Holy Family
Provider # 0026286
Related Party

Owners	Related Nursing Homes	City
Resurrection HealthCare	St. Benedict Home	Niles
	St Andrew Home	Niles
	MaryHaven	Glenview

Other Related Business Entities

Name	City	Type of Business